TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding RX

Respondent Name
Electric Insurance Co

MFDR Tracking Number
M4-18-0427-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $586.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "However, the Acetaminophen/Codeine, has been denied as it required preauthorization, but was not obtained. In conclusion, Respondent stands by the denial of the Acetaminophen/Codeine, and no monies should be awarded."

Response Submitted by: Downs • Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2017	Acetaminophen/COD #3 tablet Celecoxib 200mg capsule	$586.89	$25.33

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out pharmacy fee guidelines.
3. 28 Texas Administrative Code §134.530 sets out requirements of closed formulary claims not subject to certified networks
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable fee guideline?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "Precertification/authorization/notification absent."

   28 Texas Administrative Code §134.530 (b)(1)(A)states in pertinent part,

   > Preauthorization for claims subject to the Division's closed formulary.
   >
   > Preauthorization is only required for:
   >
   > drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

   Review of the May 2017 ODG Appendix A finds:

   - Acetaminophen/Codeine # 3, NDC 00093-0150, with Status "Y"
   - Celecoxib 200 mg, NDC 68180-0397-02, with Status "Y"

   As the drugs in dispute do not have an "N" status, the carrier's denial is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.503 (c)(1)(A) states,

   > (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   >
   > (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   >
   > (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   >
   > (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

Name of Drug	NDC	Billed units	AWP	Allowable	Billed amount	Lesser of billed or allowable	Carrier Paid	Amount due
Acetaminophen/Codeine	00093015010	60	0.28435	$25.33	$74.56	$25.33	$0.00	$25.33
Celecoxib 200mg capsule	68180039702	60	$7.58052	$572.54	$512.33	$512.33	$512.33	$0.00
							TOTAL	$25.33

3. The total allowable is $537.66. The carrier previously paid $512.33 on September 27, 2017 via Payment ID 14TMB175959100. The remaining allowable amount is $25.33. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $25.33.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $25.33, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		December 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.